



BUREAU TALK

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INTRODUCTION

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Time has really flown again since the April 2007 publication of the "Bureau Talk"! We have lots of information again to pass on to all of you! We also want to remind you that all the past "Bureau Talk" publications and any attachments that were published with them, can be found on our Home Care website at www.dhss.mo.gov/HomeCare. For future publications of the "Bureau Talk" the email will contain a direct link to our web site where you can view and download the current "Bureau Talk".

We are pleased to announce we have no new employees in the Bureau; however, we do have a new "name" to pass on to you. Debi Hytla married Brian Siebert on May 5, 2007. Please join the Bureau in wishing Debi and Brian many years of happiness! You can continue to reach Debi Siebert for any OASIS technical questions at 573-751-6332.

PLAN OF CORRECTIONS

RSMo 197.478 (1) states: "The Department of Health and Senior Services shall provide through their Internet web site:

- (1) The most recent survey of all home health agencies and any such findings of deficiencies and the effect the deficiency would have on such agencies...
- (2) The home health agency's proposed plan of correction; ..."

The Bureau is currently working on setting up a paperless system in which all documents will be scanned. This new process is one of the reasons the Bureau will no longer accept faxes, since they are much harder for the scanner to read. Hopefully by the end of 2007, the Bureau's website will have, for public viewing, the latest survey and plan of correction for all entities regulated by our Bureau. It is in the long range planning that this web site will allow viewing of the past three surveys for each agency.

Because of this, the Bureau would like to remind agencies that the plan of correction that they submit must be legible. Some agencies hand

PLAN OF CORRECTIONS CONTINUED

write the plan of correction. Once scanned and placed on the Internet, hand written copies are often times not legible. We are requesting that the plan of correction be typed; however, we still will accept hand written. If the public has problems discerning the penmanship and calls the bureau to assist, we will direct those calls back to your agency. If you cannot type the plan of correction directly on the 2567, you may submit a separate sheet of paper with the typed plan of correction. However, it is imperative that you put in the second column of the 2567 "See attached". Also, this is a reminder that you **must sign and date** the attachment as well as both the Federal 2567 and State forms. Without an original signature on all 3 forms the plan of correction will not be reviewed.

FAMILY CARE SAFETY REGISTRY

Effective August 28, 2007, the Family Care Safety Registry (FCSR) Worker Registration fee will increase to \$9.00. The increase results from a change in state law and is required by the Missouri State Highway Patrol. Just a reminder that none of that money goes to the FCSR, but rather the Missouri State Highway Patrol receives the whole fee amount. Any questions regarding the fee increase should be directed to the Missouri State Highway Pa-

trol at (573) 526-6153.

Family Care Safety Registry will return Worker Registration forms submitted with the incorrect fee that are postmarked on or after 8/28/07. Updated Worker Registration Forms will be available to be downloaded at www.dhss.mo.gov/FCSR on August 28, 2007, or may be obtained by contacting the FCSR at 1-866-422-6872.

Also, "Click to Pay" is now up and running! You can pay for

the Family Care Safety Registry results with a credit card. You can receive and print out the results immediately if there is no "hit" found on the employee. If there is a hit found, you can pick up the phone and call FCSR at 1-866-422-6872 and they will send the information in the mail that same day. The system has been up and running for several weeks without any glitches.

LIST SERVE

It is the goal of the Bureau to disseminate information as we receive it to our providers to keep everyone as updated as possible. In the past we have kept 3 e-mail addresses on file. However, due to continued problems for both the Bureau and your agency, i.e. firewall issues, frequent staff changes, etc., we have decided to limit the number of e-mail

contacts per agency to one. Effective immediately, all information disseminated via e-mail from the Bureau will be sent to the administrator of your agency. It is his/her responsibility to ensure the information reaches the proper agency personnel. Please send to Emily.Bruce@dhss.mo.gov the current email address for the administrator of your agency. It

is the Bureau's hope that this new system will assure each agency receives all the information disseminated from the Bureau. It is highly encouraged that the "Bureau Talk" be forwarded to all your staff.

ANNUAL STATISTICAL REPORTS

Can you believe we are talking about annual statistical reports already? Normally, about the time the holidays come around, we start talking about the annual statistical reports. What a hectic time of the year to throw more information at you! This year we decided to have a plan in advance to try to make the process go smoother.

A notice to the agency administrator from the Bureau will be

sent out via e-mail around mid-November. In this e-mail the Bureau will reference the Missouri Alliance for Home Care (MAHC) and the Missouri Hospice and Palliative Care Association (MHPCA) web sites from which the agencies can download the necessary statistical report forms. The completed annual statistical report forms will be due January 31, 2008, and as last year, are to

be submitted electronically to the respective organization whether it be MAHC or MCPHA. Please make note to capture the "race" when filling out report on the 2006 report, 16.53% answered "don't know".

Again this year, both organizations will host a teleconference to review the report and answer questions.

PROGRESS NOTES

484.48 Condition of Participation: Clinical Records Tag G236 states "A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treat-

ment, and activity orders; signed and dated clinical and **progress notes**; copies of summary reports sent to the attending physician; and a discharge summary."

It was announced at the Federal Advanced Surveyor Training in April of this year that progress notes would no longer be a requirement for home health.

However, if an agency's policy states that they require progress notes, the surveyor would expect to see adherence to this policy.

Please note all other documentation requirements noted in the regulation, i.e., 60-day summaries addressing all disciplines, must still be met.

BRANCH/SATELLITE

We have been informed that agencies that have submitted 855's to their Fiscal Intermediary (CAHABA) have been receiving a notice back from them stating "Pending approval of Regional Office". This is to advise you that Missouri has been given authority

by Centers for Medicare and Medicaid Services (CMS) Regional Office in Kansas City to approve branches and satellites. Therefore, if you have already received an approval letter from the Bureau of Home Care and Rehabilitative Standards regarding your branch or satel-

lite request you may disregard the statement in the CAHABA letter.

Please remember: There will be no satellites approved across state lines. Missouri has no reciprocal agreements for Hospice.

Requesting Exceptions to Serve Patients in Unauthorized Territory:

Because we can no longer accept any information via fax containing patient identifiable information, any request to serve a patient in unauthorized territory will need to be phoned in to our office. Please have available the following information:

- Patient name and address
- Physician's name
- Patient's diagnosis
- Anticipated time on service
- How many miles over your approved area

If the bureau has received several requests within several weeks to seek an exception we are going to be inquiring if your agency would like to make a permanent geographic request for expansion.

OFFICE ISSUES

The office support staff would like to remind agencies of a couple issues that have come up again over the last several months:

- Remember to send separate documentation for each agency change you are requesting. The following all require different processes and should be addressed in separate correspondence
 1. Administrator, nursing supervisor, telephone and address changes
 2. Branch or Satellite requests
 3. Expansion of counties
- The agency CCN (CMS Certification Number) needs to be used on all correspondence. This was in the past referred to as the Medicare Provider number.
- Due to the fact the Bureau is currently going to a paperless system and faxed copies do not scan clearly, information must be sent via the postal system. Only during extenuating circumstances, when requested by bureau staff, should a fax be sent.
- Also in relation to the scanning issues, if agency's would please not staple any information.

CMS Mission and Priority Document FY 08

Fiscal year FY 07 will soon be coming to a close! The surveyors are winding up their surveys required by CMS for this past fiscal year. CMS is already getting the states prepared for the next fiscal year by sending out the draft publication of the CMS Mission and Priority Document FY 08. Since it is only a draft, it is not certain it will come to pass; however, it looks like Medicare Hospice surveys may be increased. Last year, Tier IV Medicare hospice surveys, were to be completed on an average of every 6 years. The FY 08 document has moved that to an average of 4.5 years. The Bureau believes, with home health and hospice agencies being on the forefront for fraud and abuse with the Office of Inspector General (OIG) and being more highly scrutinized by the public in general, CMS will more closely be monitoring these providers.

BROADBAND CONNECTIVITY

Beginning in July, CMS will begin switching from AT&T's dial up service for assessment submissions and reports to broadband on a state by state basis. In order to use the broadband service it will be necessary to update to AT&T's Global Network Client to version 7.0, version date 5/24/07. Version 6.9 will work on Microsoft operating systems other than Vista. You can check which version you have by launching the client, left mouse click 'Help' on the top menu bar, and select 'About'. The version number and date will be displayed.

You can obtain a copy of the new client by logging onto www.qtso.com and click the MDCN Information link in the blue outlined box on the right hand side of the page.

The new client is much larger than the older clients and it may take a long time to download. As an alternative to downloading you can request a CD version be mailed to you by emailing a request to mdcn.mco@palmettogba.com.

- The schedule of which states will switch to broadband by month is also published on the QTSO website.

With the use of broadband there may be some additional considerations depending on your particular environment. For example, if you are on a corporate wide area network (WAN) or a local area network (LAN) your network administrator will probably have to configure your network to allow access to the network's broadband connection through the new client. Instructions are provided for your administrator. Administrators please read these instructions carefully before you attempt to resolve network issues. Since there are a variety of configuration options for networks it may be necessary to work through some of the issues with the AT&T help desk. This is the reason why we are transitioning on a state by state basis. If you are able to install the new client and begin using the broadband connection without assistance from AT&T you may begin using the new client anytime after July 1st. If you need assistance you will have to wait until your designated month to call AT&T. The Help Desk number for facilities is 800-905-2069. The Help Desk number for States is 877-486-7240.

If you are in an area where there is no broadband service available you will have to submit a waiver request to CMS to continue using the phone modem method. The waiver form is also on the QTSO website.

If you have any questions, please contact Debi Siebert at 573-751-6332 or by email at Debi.Siebert@dhss.mo.gov.

HOME HEALTH FRAUD

On July 17, 2007, U.S. Department of Health & Human Services (DHHS) Secretary, Michael Leavitt, announced an initiative designed to protect Medicare beneficiaries from fraudulent Home Health Agency providers. This will consist of a two-year project that will focus on preventing deceptive providers from operating in the greater Los Angeles and Houston areas. This press release can be viewed at the following web site: <http://www.hhs.gov/news/press/2007pres/07/pr20070717a>.

HOSPICE INCLUDED IN HHS OIG WORK PLAN

The two focuses will be on Hospice payments to Nursing Facilities, and Hospice plans of care and appropriate payments. The Office of Inspector General (OIG) will determine whether hospice payments for services for dually eligible patients residing in nursing facilities are accurate. The OIG has looked at this in the past and found that nursing home hospice patients received nearly 46 % fewer nursing and aide visits than hospice patients residing in their own homes. They will also be looking at services that are provided by both the nursing home and the hospice to see if there are overlaps and if so, identify any duplication in reimbursement by Medicare hospices and Medicaid.

When looking at the plans of care (POC), OIG will focus on determining if the POC reflects the assessments. This review also determine whether the hospice patients are receiving services billed for and if those services were billed at the correct level of care.

REPORTING OF ADDITIONAL DATA TO DESCRIBE SERVICES ON HOSPICE CLAIMS

The CMS Medicare Claims Processing Manual, chapter 11 Processing Hospice Claims, Transmittal 1304, dated July 20, 2007, has new instructions which consist of expanding the claim data reporting requirements for Medicare hospice claims. Effective January 1, 2008, for each week beginning on Sunday and ending on Saturday, hospice providers are to indicate the number of services/visits provided by nurses (registered, licensed and /or nurse practitioner), home health aides, and social workers. Physicians, and nurse practitioners serving as the beneficiary's attending physician. Please visit the following web site for all the details:

<http://www.cms.hhs.gov/transmittals/downloads/R1304CP.pdf>

News from the MOO arena...



By Joyce Rackers, R.N.

- Just when we thought there was plenty of activity in the MOO arena we find yet more changes are on the way! As you all are aware, with the Proposed 2007 Home Health PPS Rule comes Proposed OASIS Changes. Please find attached the "Summary of the Proposed OASIS Changes OASIS-B1 (1/2008) Compared with Current OASIS-B1 (12/2002)". **(ATTACHMENT 1)** This is a brief synopsis of what changes are proposed once the Final Home Health PPS rule is adopted. These changes would go into effect on 1/1/2008.
- In September, I will be attending the OASIS Education Coordinator Conference/Training in Dallas, Texas. At that time I hope to gain more information regarding the upcoming changes. All my training materials will need to be updated; therefore, it is the plan at this time to hold on any further OASIS training for the remainder of the year 2007. In January and February 2008 the Bureau will hold multiple larger trainings here in Jefferson City in order to disseminate the new information as quickly as possible to all the home health agencies. As soon as plans are finalized we will notify you. In the meantime, I am always available by phone at 573-751-6336 for any questions you may have.
- It is the goal of CMS to gain accuracy and consistency across the country in answering the OASIS questions. In order to reach this goal, CMS has now contracted with the OASIS Answers, Inc. Team/OASIS Certificate & Competency Board (OCCB) to answer all OASIS questions. Therefore, any question you have that I am unable to answer using resources provided by CMS, OASIS Answers, Inc. or the OCCB, I will forward to CMS. OASIS Answers, Inc./OCCB will forward their answer to me within 7-10 working days.

In order to enhance the value of the responses formulated and to broaden their distribution and use in enhancing data accuracy, select Question & Answers (Q&As) will be reviewed, compiled into a quarterly summary and distributed as quarterly (dated) CMS OCCB Q&As. The first two quarterly updates dated May 2007 and July 2007 can be found in **Attachments 2 and 3.**

- In February 2007, the National Pressure Ulcer Advisory Panel (NPUAP) redefined the definition of a pressure ulcer and the stages of pressure ulcers, including the original 4 stages and adding 2 stages on deep tissue injury and unstageable pressure ulcers. (**Attachment 4**) At this time the OASIS items have not been changed to reflect the new staging. Therefore, until the OASIS items are updated you will continue to stage your ulcers as the OASIS questions allow. However, for M0450 and M0460 you will need to begin using the new guidelines for determining what is considered an unstageable pressure ulcer.

The updated guidelines state:

- **Unstageable - the wound must have full thickness tissue loss in which the ENTIRE base of the ulcer is covered by slough and/or eschar.**
- **Stage IV ulcer - full thickness tissue loss with exposed bone, tendon or muscle. Sough or eschar MAY BE PRESENT on some parts of the wound bed.**

Prior to the new guidelines published in February of 2007, a pressure ulcer with any amount of slough or eschar, even if bone was visible, could not be staged.

For further information please refer to the National Pressure Ulcer Advisory Panel website www.npuap.org.